

STATEMENT OF EMERGENCY

907 KAR 1:900E

(1) This emergency administrative regulation is being promulgated to transform the Kentucky Medicaid program into KyHealth Choices – a program which tailors benefit packages to individual needs and circumstances. The benefit packages established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with the Deficit Reduction Act of 2005, is necessary to maintain the viability of the program, to provide innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries, and to promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

(2) This emergency administrative regulation shall be replaced by an identical ordinary administrative regulation to be concurrently filed with the Regulations Compiler.

Ernie Fletcher
Governor

Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Health and Family Services

3 Division of Administration and Financial Management

4 (New Emergency Administrative Regulation)

5 907 KAR 1:900E. KyHealth Choices Benefit Packages.

6 RELATES TO: KRS 205.520, 205.560, 205.6312, 205.6481 - 6497, 205.8451,
7 319A.010, 327.010, 334A.020, 20 CFR §416.2001, 42 CFR 433.56, 435, 436.3, 440.30,
8 440.40, 440.60, 440.70, 440.110, 440.120, 440.130, 440.170, 441.20, 441.21, 441.35,
9 441.40, 457.310, 45 C.F.R. 233.100, 42 U.S.C. 416, 423, 1382c, 1383c, 1396a, b, c, d,
10 o, r-6, r-8, 1397aa, Social Security Act 1902(a)(10)(A), 1902(a)(52), 1902(aa),
11 1902(l)(B),(C),(D), 1905(a), 1905(a)(4)(C), 1905(o), 1931, 2006 GA HB 380

12 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), Public Law
13 109-171

14 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
15 Services, Department for Medicaid Services has responsibility to administer the
16 Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation,
17 to comply with any requirement that may be imposed or opportunity presented by
18 federal law for the provision of medical assistance to Kentucky's indigent citizenry. This
19 administrative regulation, as authorized by KRS 194A.030(2), 194A.050(1), 205.520(3)
20 and Public Law 109-171, establishes the Medicaid program KyHealth Choices benefit
21 packages.

1 Section 1. Definitions.

2 (1) "ABI waiver" means the department's acquired brain injury waiver program.

3 (2) "Caretaker relative" means a relative:

4 (a) With whom a child is, or shall be, placed by the Cabinet for Health and Family
5 Services; and

6 (b) Who is seeking to qualify as a kinship caregiver.

7 (3) "Categorically needy children" means individuals under eighteen (18) years of age
8 receiving Title IV-E benefits, SSI, or SSP, or who would have been eligible to receive
9 Title IV-A benefits prior to July 16, 1996.

10 (4) "CHIP" means children's health insurance program.

11 (5) "Coinsurance" means a percentage of the cost of a Medicaid benefit that a
12 recipient is required to pay.

13 (6) "Comprehensive choices" means a benefit package for individuals who meet the
14 nursing facility patient status criteria established in 907 KAR 1:022, receive services
15 through either a nursing facility in accordance with 907 KAR 1:022, the acquired brain
16 injury waiver program in accordance with 907 KAR 3:090, the home and community
17 based waiver program in accordance with 907 KAR 1:160 or the model waiver II
18 program in accordance with 907 KAR 1:595.

19 (7) "Copayment" or "co-pay" means a dollar amount portion of the cost of a Medicaid
20 benefit that a recipient is required to pay.

21 (8) "Department" means the Department for Medicaid Services or its designee.

22 (9) "Family choices" means a benefit package for individuals covered pursuant to:
23 Section 1902(a)(10)(A)(i)(I) and 1931 of the Social Security Act, Section 1902(a)(52)

1 and 1925 of the Social Security Act (excluding children eligible under Part A or E of title
2 IV), Section 1902 (a)(10)(A)(i)(IV) as described in 1902(l)(1)(B) of the Social Security
3 Act, Section 1902(a)(10)(A)(i)(VI) as described in 1902 (l)(1)(C) of the Social Security
4 Act, Section 1902 (a)(10)(A)(i)(VII) as described in 1902 (l)(1)(D) of the Social Security
5 Act, and 42 CFR 457.310.

6 (10) "Global choices" means the department's default benefit package and shall be for
7 the following populations:

8 (a) Caretaker relatives of children who:

- 9 1. Receive K-TAP and are deprived due to death, incapacity or absence;
- 10 2. Do not receive K-TAP and are deprived due to death, incapacity or absence; or
- 11 3. Do not receive K-TAP and are deprived due to unemployment;

12 (b) Individuals aged sixty-five (65) and over who receive SSI:

- 13 1. But do not meet nursing facility patient status criteria in accordance with 907 KAR
14 1:022; or
- 15 2. And receive SSP but do not meet nursing facility patient status criteria in accordance
16 with 907 KAR 1:022;

17 (c) Blind individuals who receive SSI:

- 18 1. Who do not meet nursing facility patient status criteria in accordance with 907 KAR
19 1:022;
- 20 2. And SSP but do not meet nursing facility patient status criteria in accordance with
21 907 KAR 1:022;

22 (d) Disabled individuals who receive SSI:

- 23 1. Who do not meet nursing facility patient status criteria in accordance with 907 KAR

1:022, including children;

2. And SSP but do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits and are eligible for “pass through” Medicaid benefits but do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits and are eligible for “pass through” Medicaid benefits but do not meet nursing facility patient status in accordance with 907 KAR 1:022; or

(g) Disabled individuals who have lost SSI or SSP benefits and are eligible for “pass through” Medicaid benefits but do not meet nursing facility patient status in accordance with 907 KAR 1:022.

(11) “HCB waiver” means the department’s home and community based waiver program established in 907 KAR 1:160.

(12) “ICF MR DD” means an intermediate care facility for individuals with mental retardation or a developmental disability.

(13) “KCHIP” means Kentucky Children’s Health Insurance Program.

(14) “KCHIP Children – Medicaid Expansion Program” means a department program established in 907 KAR 4:020.

(15) “KCHIP Children – Separate CHIP Program” means a department program established in 907 KAR 4:030.

(16) “Kinship caregiver” means the qualified caretaker relative of a child with whom the child is placed by the Cabinet for Health and Family Services as an alternative to

1 foster care.

2 (17) "K-TAP" means Kentucky's version of the federal block grant program of
3 Temporary Assistance for Needy Families (TANF), a money payment program for
4 children who are deprived of parental support or care due to:

5 (a) Death;

6 (b) Continued voluntary or involuntary absence;

7 (c) Physical or mental incapacity of one (1) parent or stepparent if two (2) parents are
8 in the home; or

9 (d) Unemployment of one (1) parent if both parents are in the home.

10 (18) "Medically necessary" or "medical necessity" means that a covered benefit is
11 determined to be needed in accordance with 907 KAR 3:130.

12 (19) "Model Waiver II" means a department program established in 907 KAR 1:595.

13 (20) "Non-emergency visit" means a visit to an emergency room for treatment of a
14 condition which does not require an emergency service pursuant to 42 CFR 447.53.

15 (21) "Non-preferred brand name drug" means a brand name drug that is not on the
16 department's preferred drug list pursuant to 907 KAR 1:019.

17 (22) "Occupational therapy" means the practice of occupational therapy pursuant to
18 KRS 319A.010(2), as covered by the department, and provided by an occupational
19 therapist as defined in KRS 319A.010(3).

20 (23) "Optimum choices" means a benefit package for individuals who meet the
21 intermediate care facility for individuals with mental retardation or a developmental
22 disability patient status criteria established in 907 KAR 1:022, who receive services
23 through either an intermediate care facility for individuals with mental retardation or a

developmental disability in accordance with 907 KAR 1:022, or who receive services through the supports for community living waiver program in accordance with 907 KAR 1:145.

(24) "Other populations" means SSI individuals, caretaker relatives, and individuals eligible through the department's breast and cervical cancer treatment program pursuant to 907 KAR 1:805 who are subject to copayment or coinsurance.

(25) "Physical therapy" means physical therapy as defined in KRS 327.010(1), as covered by the department, and provided by a physical therapist as defined in KRS 327.010(2) and as covered by the department.

(26) "Preferred brand name drug" means a brand name drug for which no generic equivalent exists and is available via the department's supplemental rebate program pursuant to 907 KAR 1:019.

(27) "Recipient" is defined in KRS 205.8451 and applies to an individual who has been determined eligible to receive benefits under the state's Title XIX or Title XXI program in accordance with 907 KAR Chapters 1 through 4.

(28) "SCL waiver" means the department's supports for community living waiver program established in 907 KAR 1:145.

(29) "Speech therapy" means the practice of speech pathology as defined in KRS 334A.020(4), as covered by the department, and provided by a speech-language pathologist as defined in KRS 334A.020(3).

(30) "SSI" means the Social Security Administration program called supplemental security income.

(31) "SSP" means state supplemental payments for individuals who are aged, blind

or disabled and in accordance with 921 KAR 2:015.

Section 2. Benefit Package Assignment.

(1) The department shall assign each recipient to the appropriate benefit package - comprehensive choices, family choices, global choices, or optimum choices - pursuant to the definitions established in Section 1(6), (9), (10) and (22) and based on the recipient's medical needs or circumstances.

(2)(a) The provisions established in this administrative regulation shall apply to a recipient and, except for cost-sharing provisions, shall supersede any contradictory provision established in any other department administrative regulation if any contradiction exists.

(b) If any cost-sharing provision established in this administrative regulation differs from a cost-sharing provision established in 907 KAR 1:604, the cost-sharing provision established in 907 KAR 1:604 shall supersede the cost-sharing provision established in this administrative regulation.

(3) If a recipient's medical needs or circumstances change, the department may assign the recipient to a more appropriate benefit package.

(4)(a) A recipient whose medical needs or circumstances are appropriate for the comprehensive choices benefit package may elect to not be assigned to the comprehensive choices benefit package.

(b) The department shall assign a recipient who elects to not be assigned to the comprehensive choices benefit package to the global choices benefit package.

(5)(a) A recipient may request to be assigned to a different benefit package by notifying the department.

(b) If a recipient requests to be assigned to a different benefit package, the department shall examine the recipient's medical needs or circumstances and determine if the individual shall be placed in a different benefit package.

Section 3. Comprehensive Choices.

(1) Following is a grid establishing the comprehensive choices benefit package provisions:

Benefit	NF Level of Care (including ABI waiver, Model Waiver II, and HCB Waiver)
Annual Non-pharmacy Benefit Cost-sharing Maximum	\$225 per calendar year
Annual Pharmacy Benefit Cost-sharing Maximum	\$225 per calendar year
Acute Inpatient Hospital Admission	\$10 co-pay
Laboratory, Diagnostic and Radiology Services	\$0 co-pay
Outpatient Hospital or Ambulatory Surgical Center	\$3 co-pay
Physician Office Services	\$0 co-pay
Behavioral Health Services	\$0 co-pay
Allergy Services	\$0 co-pay

Preventive Services	\$0 co-pay
Emergency Ambulance	\$0 co-pay
Dental Services Cleanings shall be limited to two (2) per twelve (12) months for children under age twenty-one (21) and one (1) per twelve (12) months for adults twenty-one (21) and over; X-rays shall be limited to one (1) set per twelve (12) months regardless of age	\$0 co-pay
Family Planning	\$0 co-pay
Occupational Therapy (Limited to thirty (30) visits per twelve (12) months)	\$0 co-pay
Physical Therapy (Limited to thirty (30) visits per twelve (12) months)	\$0 co-pay
Speech Therapy (Limited to thirty (30) visits per twelve (12) months)	\$0 co-pay
Hospice (non-institutional)	\$0 co-pay
Non-emergency Transportation	\$0 co-pay
Chiropractic Services (Children under the age of twenty-one (21) shall be limited to seven (7) visits per twelve (12) months; Adults age twenty-one (21) and over shall be limited to fifteen (15) visits per twelve (12) months)	\$0 co-pay

<p>Prescription Drugs for Recipients who do not have Medicare Part D</p> <p>(Limited to four (4) prescriptions per month with a maximum of three (3) brand name prescriptions)</p>	<p>\$1 co-pay for generic or atypical anti-psychotic if no generic equivalent for the atypical anti-psychotic exists;</p> <p>\$2 co-pay for preferred brand name drug; five (5) percent coinsurance for non-preferred brand name drug</p>
<p>Emergency Room</p>	<p>\$3 co-pay for a non-emergency visit</p>
<p>Hearing Services</p> <p>(All hearing service coverage shall be limited to children under age twenty-one (21))</p>	<p>\$0 co-pay</p>
<p>Hearing Aids</p>	<p>\$0 co-pay</p>

(Coverage shall be limited to children under age twenty-one (21) and to \$1,400 per ear every thirty-six (36) months)	
Audiometric Services (Coverage shall be limited to children under age twenty-one (21) and to one (1) audiologist visit per twelve (12) months)	\$0 co-pay
Vision Services (All vision service coverage shall be limited to children under age twenty-one (21); Eyeglass coverage shall be limited to \$400 per twelve (12) months)	\$0 co-pay
Prosthetic Devices	\$0 co-pay
Home Health Services	\$0 co-pay
Durable Medical Equipment	Three (3) percent coinsurance up up to a maximum of \$15 per month
Early Periodic Screening and Diagnosis (EPSD)	\$0 co-pay
Treatment (T) Services for Conditions Identified through EPSD (Coverage shall be limited to children under age twenty-one (21))	\$0 co-pay
Substance Abuse Services (Coverage shall be limited to EPSDT services and to women pursuant to 907 KAR 3:110)	\$0 co-pay

Maternity Services (Coverage shall include nurse mid-wife services, pregnancy-related services, services for other conditions that might complicate pregnancy or sixty (60) days postpartum pregnancy-related services)	\$0 co-pay
Podiatry Services	\$2 co-pay
End Stage Renal Disease and Transplants	\$0 co-pay

(2) Physician office services include services provided by physicians, certified pediatric and family nurse practitioners, nurse midwives, federally qualified health centers, rural health clinics, primary care centers, advanced registered nurse practitioners, and physician assistants.

(3) Behavioral health services include mental health rehabilitation or stabilization, behavioral support, psychological services and inpatient psychiatric services.

(4) To be covered by the department, an occupational therapy, physical therapy or speech therapy visit shall be prior authorized.

(5) Except for the hearing aid coverage monetary limit, the eyeglass coverage monetary limit, and any age limit, the limits established in this Section of this administrative regulation shall be soft in that they may be over-ridden if the department determines that the additional benefit is medically necessary.

Section 4. Family Choices.

(1) Following is a grid establishing the family choices benefit package provisions:

Benefit	Children of Caretaker	Categorically Needy Children	KCHIP Children – Medicaid	KCHIP Children – Separate

	Relatives		Expansion Program	CHIP Program
Annual Non-pharmacy Benefit Cost-sharing Maximum	\$225 per calendar year	\$225 per calendar year	\$225 per calendar year	\$225 per calendar year
Annual Pharmacy Benefit Cost-sharing Maximum	\$225 per calendar year	\$225 per calendar year	\$225 per calendar year	\$225 per calendar year
Acute Inpatient Hospital Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Laboratory, Diagnostic and Radiology Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Outpatient Hospital or Ambulatory Surgical Center	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay

Services				
Physician Office Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Behavioral Health Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Allergy Services	\$0 co-pay	\$0 co-pay	\$2 co-pay for office visit and testing; \$0 co-pay for injections	\$2 co-pay for office visit and testing; \$0 co-pay for injections
Preventive Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Emergency Ambulance	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Dental Services (Cleanings shall be limited to two (2) per twelve (12) months; X-rays shall be limited to one (1) set per	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay

twelve (12) months)				
Family Planning	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Occupational Therapy (Limited to fifteen (15) visits per twelve (12) months)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Physical Therapy (Limited to fifteen (15) visits per twelve (12) months)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Speech Therapy (Limited to fifteen (15) visits per twelve (12) months)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Hospice (non-	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay

institutional)				
Non-emergency transportation (Not Covered for KCHIP Children – Separate CHIP Program)	\$0 co-pay	\$0 co-pay	\$0 co-pay	Not Covered
Chiropractic Services (Limited to seven (7) visits per twelve (12) months)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Prescription Drugs	\$0 co-pay	\$0 co-pay	\$1 co-pay for generic or atypical anti-psychotic if no generic equivalent for the atypical anti-psychotic	\$1 co-pay for generic or atypical anti-psychotic if no generic equivalent for the atypical anti-psychotic

			exists; \$2 co-pay for preferred brand name drug; \$3 for non-preferred brand name drug	exists; \$2 co-pay for preferred brand name drug; \$3 for non-preferred brand name drug
Emergency Room	\$0 co-pay	\$0 co-pay	\$3 co-pay for a non-emergency visit	\$3 co-pay for a non-emergency visit
Hearing Aids (\$1,400 maximum per ear every thirty-six (36) months)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Audiometric Services (One (1) audiologist visit per twelve (12) months)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Vision Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay

(Eyeglass coverage shall be limited to \$400 per twelve (12) months)				
Prosthetic Devices (\$1,500 maximum per twelve (12) months)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Home Health Services (Limited to twenty-five (25) visits per twelve (12) months)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Durable Medical Equipment	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Early Periodic Screening and Diagnosis	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay

(EPSD)				
Treatment (T) Services for Conditions Identified through EPSD (Not covered for KCHIP Children – Separate CHIP Program)	\$0 co-pay	\$0 co-pay	\$0 co-pay	Not Covered
Substance Abuse Services (Coverage shall be limited to EPSDT services and to women pursuant to 907 KAR 3:110; coverage shall not be provided for KCHIP	\$0 co-pay	\$0 co-pay	\$0 co-pay	Not Covered

Children – Separate CHIP Program)				
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2 (2) Physician office services include services provided by physicians, certified
3 pediatric and family nurse practitioners, nurse midwives, federally qualified health
4 centers, rural health clinics, primary care centers, advanced registered nurse
5 practitioners, and physician assistants.

6 (3) Behavioral health services include mental health rehabilitation or stabilization,
7 behavioral support, psychological services and inpatient psychiatric services.

8 (4) To be covered by the department, an occupational therapy, physical therapy or
9 speech therapy visit shall be prior authorized.

10 (5) Except for the hearing aid coverage monetary limit, the eyeglass coverage
11 monetary limit, and any age limit, the limits established in this Section of this
12 administrative regulation shall be soft in that they may be over-ridden if the department
13 determines that the additional benefit is medically necessary.

14 Section 5. Global Choices.

15 (1) Following is a grid establishing the global choices benefit package provisions:

Benefit	Individuals Exempt from Cost- sharing	Other Populations
Annual Non-pharmacy Benefit Cost-sharing	\$225 per	\$225 per calendar

Maximum	calendar year	year
Annual Pharmacy Benefit Cost-sharing Maximum	\$225 per calendar year	\$225 per calendar year
Acute Inpatient Hospital Services	\$0 co-pay	\$50 co-pay per admission
Laboratory, Diagnostic and Radiology Services	\$0 co-pay	\$3 co-pay
Outpatient Hospital or Ambulatory Surgical Centers	\$0 co-pay	\$3 co-pay
Physician Office Services	\$0 co-pay	\$2 co-pay
Behavioral Health Services	\$0 co-pay	\$0 co-pay
Allergy Services	\$0 co-pay	\$0 co-pay
Preventive Services	\$0 co-pay	\$0 co-pay
Emergency Ambulance	\$0 co-pay	\$0 co-pay
Dental Services (Cleanings shall be limited to two (2) per twelve (12) months for children under age twenty-one (21) and one (1) per twelve (12) months for adults twenty-one (21) and over; X-rays shall be limited to one (1) set per twelve (12) months regardless of age)	\$0 co-pay	\$2 co-pay
Family Planning	\$0 co-pay	\$0 co-pay

Occupational Therapy (Limited to fifteen (15) visits per twelve (12) months)	\$0 co-pay	\$2 co-pay
Physical Therapy (Limited to fifteen (15) visits per twelve (12) months)	\$0 co-pay	\$2 co-pay
Speech Therapy (Limited to ten (10) visits per twelve (12) months)	\$0 co-pay	\$1 co-pay
Hospice (non-institutional)	\$0 co-pay	\$0 co-pay
Non-emergency Transportation	\$0 co-pay	\$0 co-pay
Chiropractic Services (Children under the age of twenty-one (21) limited to seven (7) visits per twelve (12) months; Adults aged twenty-one (21) and over limited to fifteen (15) visits per twelve (12) months)	\$0 co-pay	\$2 co-pay
Prescription Drugs for Recipients who do not have Medicare Part D Coverage (limited to four (4) prescriptions per month with a maximum of three (3) brand name drug prescriptions)	\$0 co-pay	\$1 co-pay for generic or atypical anti-psychotic if no generic equivalent for the atypical anti-psychotic exists; \$2 co-pay for preferred brand name drug; five (5) percent

		coinsurance for non-preferred brand name drug
Emergency Room	\$0 co-pay	\$3 co-pay for a non-emergency visit
Hearing Services (All hearing services shall be limited to children under age twenty-one (21))	\$0 co-pay	\$0 co-pay
Hearing Aids (Coverage shall be limited to children under age twenty-one (21) and to \$1,400 per ear every thirty-six (36) months)	\$0 co-pay	\$0 co-pay
Audiometric Services (Coverage shall be limited to children under age twenty-one (21) and to one (1) audiologist visit per twelve (12) months)	\$0 co-pay	\$0 co-pay
Vision Services (All vision service coverage shall be limited to children under age twenty-one (21); Eyeglass coverage shall be limited to \$200 per twelve (12) months)	\$0 co-pay	\$0 co-pay
Prosthetic Devices	\$0 co-pay	\$0 co-pay

Home Health Services	\$0 co-pay	\$0 co-pay
Durable Medical Equipment	\$0 co-pay	Three (3) percent coinsurance not to exceed \$15 per month
Early Periodic Screening and Diagnosis (EPSD)	\$0 co-pay	\$0 co-pay
Treatment (T) Services for Conditions Identified through EPSD (Coverage shall be limited to children under age twenty-one (21))	\$0 co-pay	\$0 co-pay
Substance Abuse Services (Coverage shall be limited to EPSDT services and to women pursuant to 907 KAR 3:110)	\$0 co-pay	\$0 co-pay
Maternity Services (Coverage shall include nurse mid-wife services, pregnancy-related services, services for other conditions that might complicate pregnancy or sixty (60) days postpartum pregnancy-related services)	\$0 co-pay	\$0 co-pay
Podiatry Services	\$0 co-pay	\$2 co-pay
End Stage Renal Disease and Transplants	\$0 co-pay	\$0 co-pay

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- 2 (2) Physician office services includes services provided by physicians, certified
- 3 pediatric and family nurse practitioners, nurse midwives, federally qualified health

centers, rural health clinics, primary care centers, advanced registered nurse practitioners, and physician assistants.

(3) Behavioral health services include mental health rehabilitation or stabilization, behavioral support, psychological services and inpatient psychiatric services.

(4) To be covered by the department, an occupational therapy, physical therapy or speech therapy visit shall be prior authorized.

(5) Except for the hearing aid coverage monetary limit, the eyeglass coverage monetary limit, and any age limit, the limits established in this Section of this administrative regulation shall be soft in that they may be over-ridden if the department determines that the additional benefit is medically necessary.

Section 6. Optimum Choices

(1) Following is a grid establishing the optimum choices benefit package provisions:

Benefit	ICF MR DD Level of Care (including SCL waiver)
Annual Non-pharmacy Benefit Cost-sharing Maximum	\$225 per calendar year
Annual Pharmacy Benefit Cost-sharing Maximum	\$225 per calendar year
Acute Inpatient Hospital Services	\$10 co-pay

Laboratory, Diagnostic and Radiology Services	\$0 co-pay
Outpatient Hospital or Ambulatory Surgical Centers	\$3 co-pay
Physician Office Services*	\$0 co-pay
Behavioral Health Services**	\$0 co-pay
Allergy Services	\$0 co-pay
Preventive Services	\$0 co-pay
Emergency Ambulance	\$0 co-pay
Dental Services (Cleanings shall be limited to two (2) per twelve (12) months for children under age twenty-one (21) and one (1) per twelve (12) months for adults twenty-one (21) and over; X-rays shall be limited to one (1) set per twelve (12) months regardless of age)	\$0 co-pay
Family Planning	\$0 co-pay
Occupational Therapy (Limited to thirty (30) visits per twelve (12) months)	\$0 co-pay
Physical Therapy (Limited to thirty (30) visits per twelve (12) months)	\$0 co-pay
Speech Therapy (Limited to thirty (30) visits per twelve (12) months)	\$0 co-pay
Hospice (non-institutional)	\$0 co-pay
Non-emergency Transportation	\$0 co-pay

<p>Chiropractic Services</p> <p>(Children under the age of twenty-one (21) shall be limited to seven (7) visits per twelve (12) months;</p> <p>Adults age twenty-one (21) and over shall be limited to fifteen (15) visits per twelve (12) months)</p>	<p>\$0 co-pay</p>
<p>Prescription Drugs (for members who do not have Medicare Part D)</p> <p>Prescription Drugs for Recipient who do not have Medicare Part D</p> <p>(Limited to four (4) prescriptions per month with a maximum of three (3) brand name prescriptions)</p>	<p>\$1 co-pay for generic or atypical anti-psychotic if no generic equivalent for the atypical anti-psychotic exists;</p> <p>\$2 co-pay for preferred brand name drug; five (5) percent coinsurance for non-preferred brand name drug</p>
<p>Emergency Room</p>	<p>\$3 co-pay for a non-emergency</p>

	visit
Hearing Services (All hearing service coverage shall be limited to children under age twenty-one (21))	\$0 co-pay
Hearing Aids (Coverage shall be limited to children under age twenty-one (21) and to \$1,400 per ear every thirty-six (36) months)	\$0 co-pay
Audiometric Services (Coverage shall be limited to children under age twenty-one (21) and to one (1) audiologist visit per twelve (12) months)	\$0 co-pay
Vision Services (All vision services shall be limited to children under age twenty-one (21); Eyeglass coverage shall be limited to \$400 per twelve (12) months)	\$0 co-pay
Prosthetic Devices	\$0 co-pay
Home Health Services	\$0 co-pay
Durable Medical Equipment	Three (3) percent coinsurance up to a maximum of \$15 per month
Early Periodic Screening and Diagnosis (EPSD)	\$0 co-pay

Treatment (T) Services for Conditions Identified through EPSD (Coverage shall be limited to children under age twenty-one (21))	\$0 co-pay
Substance Abuse Services (Coverage shall be limited to EPSDT services and to women pursuant to 907 KAR 3:110)	\$0 co-pay
Maternity Services (Coverage shall include nurse mid-wife services, pregnancy-related services, services for other conditions that might complicate pregnancy or sixty (60) days postpartum pregnancy-related services)	\$0 co-pay
Podiatry Services	\$2 co-pay
End Stage Renal Disease and Transplants	\$0 co-pay

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2 (2) Physician office services includes services provided by physicians, certified
3 pediatric and family nurse practitioners, nurse midwives, federally qualified health
4 centers, rural health clinics, primary care centers, advanced registered nurse
5 practitioners, and physician assistants.

6 (3) Behavioral health services include mental health rehabilitation or stabilization.

7 (4) To be covered by the department, an occupational therapy, physical therapy or
8 speech therapy visit shall be prior authorized.

9 (5) Except for the hearing aid coverage monetary limit, the eyeglass coverage
10 monetary limit, and any age limit, the limits established in this Section of this
11 administrative regulation shall be soft in that they may be over-ridden if the department

determines that the additional benefit is medically necessary.

Section 7. Copayment Provisions.

(1) The copayments established in 907 KAR 1:604 shall supersede any copayments established in this administrative regulation if any contradiction exists.

(2) The department shall impose no cost sharing for the following:

(a) A service furnished to an individual under eighteen (18) years of age required to be provided medical assistance under Social Security Act 1902(a)(10)(A)(i), including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Title IV, Part E, without regard to age;

(b) A preventive service (for example, well baby and well child care and immunizations) provided to a child under eighteen (18) years of age regardless of family income;

(c) A service furnished to a pregnant woman, if the service relates to the pregnancy or to any other medical condition which may complicate the pregnancy;

(d) A service furnished to a terminally ill individual who is receiving hospice care as defined in Social Security Act 1905(o);

(e) A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with mental retardation or a developmental disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal

1 needs;

2 (f) An emergency service as defined by 42 CFR 447.53;

3 (g) A family planning service or supply as described in Social Security Act

4 1905(a)(4)(C); or

5 (h) A service furnished to a woman who is receiving medical assistance via the

6 application of Social Security Act 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

7 Section 8. Covered Service Appeal. An appeal of a department decision regarding a

8 a covered service for a Medicaid recipient based upon an application of this

9 administrative regulation shall be in accordance with 907 KAR 1:563.

907 KAR 1:900E

REVIEWED:

Date

J. Thomas Badgett, MD, PhD, Acting Commissioner
Department for Medicaid Services

Date

Mike Burnside, Undersecretary
Administrative and Fiscal Affairs

APPROVED:

Date

Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:900E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502-564-6204)

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation transforms the Kentucky Medicaid program by tailoring benefit packages to individual needs and circumstances. The benefit packages established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs; family choices is designed for children; global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with Public Law 109-171 (aka the Deficit Reduction Act of 2005), will provide innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries, and will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the KyHealth Choices benefit packages in order to maintain the viability of the Medicaid program and to transform it into a program tailored to beneficiaries' needs. This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with Public Law 109-171 (aka the Deficit Reduction Act of 2005), will provide innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries, and will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes, including Public Law 109-171 (aka the Deficit Reduction Act of 2005), by maintaining the viability of the Medicaid program by transforming it into a program tailored to beneficiaries' needs. This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with Public Law 109-171 (aka the Deficit Reduction Act of 2005), will provide innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries, and will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.
 - (d) How this administrative regulation currently assists or will assist in the effective

administration of the statutes: This administrative regulation assists in the effective administration of the statutes, including Public Law 109-171 (aka the Deficit Reduction Act of 2005), by maintaining the viability of the Medicaid program by transforming it into a program tailored to beneficiaries' needs. This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with Public Law 109-171 (aka the Deficit Reduction Act of 2005), will provide innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries, and will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
 - (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
 - (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
 - (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect all Medicaid and Kentucky Children's Health Insurance (KCHIP) program beneficiaries.
- (4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: All Medicaid and KCHIP program beneficiaries will be affected by this administrative regulation in that they will be assigned to a benefit package tailored to their individual needs. The benefit packages established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs; family choices is designed for children; global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. Additionally, the transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles and personal accountability.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: DMS anticipates that this amendment will generate a savings of

approximately \$94.9 million (\$64.7 million federal funds; \$30.2 million state funds) during State Fiscal Year (SFY) 2007.

(b) On a continuing basis: DMS anticipates that this amendment will generate an increasing amount of annual savings in subsequent years, potentially topping \$100 million (\$68.2 million federal funds; \$31.8 million state funds) in savings as early as SFY 2008.

- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: A funding increase is unnecessary; however, an increase in certain designated cost-sharing amounts or imposition of new cost-sharing requirements is necessary to implement this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation increases and imposes certain designated cost-sharing requirements.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

This administrative regulation includes tiering in order to transform the Medicaid program into one tailored to individual medical needs and circumstances. The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

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FEDERAL MANDATE ANALYSIS COMPARISON

Reg. No. 907 KAR 1:900E

Agency Contact: Stuart Owen or
Stephanie Brammer-Barnes (502-564-6204)

1. Federal statute or regulation constituting the federal mandate.
Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.

This administrative regulation complies with federal statutes and regulations, including Public Law 109-171, governing the Medicaid program.
2. State compliance standards.
This administrative regulation complies with KRS 205.6312(5) by establishing cost-sharing provisions for Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o. This administrative regulation complies with KRS 205.6485(1) by establishing the premium contribution per family of health insurance coverage available under the Kentucky Children's Health Insurance Program.
3. Minimum or uniform standards contained in the federal mandate.
This administrative regulation transforms the Kentucky Medicaid program by tailoring benefit packages to individual needs and circumstances. The benefit packages established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs; family choices is designed for children; global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with Public Law 109-171 (aka the Deficit Reduction Act of 2005), will provide innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries, and will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth..
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?
This administrative regulation does not impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate.
5. Justification for the imposition of the stricter standard, or additional or different

responsibilities or requirements.

This administrative regulation is necessary to establish the KyHealth Choices benefit packages in order to maintain the viability of the Medicaid program and to transform it into a program tailored to beneficiaries' needs. This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with Public Law 109-171 (aka the Deficit Reduction Act of 2005), will provide innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries, and will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.